Sunshine Pediatrics, LLC

AUTHORIZATION TO TREAT MINOR PATIENT CONSENT FORM: UNACCOMPANIED BY PARENT/GUARDIAN OR ACCOMPANIED BY ANOTHER ADULT

Unaccompanied Minor:

I hereby authorize Sunshine Pediatrics LLC and its medical providers permission to diagnose, treat and provide medical services to my minor child, and to make insurance claims, when he or she arrive at the office unaccompanied by myself or another authorized adult.

Name of Child: _____ Date of Birth: _____

Accompanied By Another Adult:

I hereby authorize and grant, _____
an adult(s) in whose care my minor child has been entrusted, to act as my agent with respect to my minor child and to give consent to and authorize medical treatment and services rendered by Sunshine Pediatrics, LLC and its personnel, on behalf of myself and my child, in my absence. My agent(s) shall have the same access to my minor child's medical records that I have, including the right to disclose the contents to others, and to receive test results and any additional information pertinent to the care and treatment of my minor child. I also understand and agree that I remain personally and financially responsible for all medical services and treatment delivered to my child pursuant to this authorization, and that the payment of any co-payment, deductible, or co-insurance is required on the date of service, whether I am present or not.

Name of Minor Child: _____ Date of Birth: _____

Authorization and Indemnification by Signature

I hereby authorize, indemnify and hold harmless Sunshine Pediatrics, LLC and all of its officers, agents, employees, directors, insurers, successors and assigns from any and all liability for acting in reliance upon this signed authorization and consent. This authorization is valid for one (1) year following the date signed below unless withdrawn in writing by me and delivered to Sunshine Pediatrics, LLC, or restricted by the time frame set forth above.

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE